# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

**Friday, October 11, 2002**
**8:58 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

**AGENDA ITEM: Current issues in skilled nursing facility payment policy -- Susanne Seagrave**

DR. SEAGRAVE: Good morning. The purpose of this presentation is to give a brief overview of the SNF payment system and some of the key issues with that system, and to discuss our workplan for the coming year. This sector is undergoing a number of changes and has a lot of uncertainty right now. For these reasons, we are giving this overview in preparation for the more detailed payment adequacy discussions at the next few meetings.

As you know, SNFs provide skilled nursing and rehabilitation services to beneficiaries following an acute care hospitalization of at least three days. About 90 percent of SNFs are part of nursing homes. We call these freestanding. And the rest are associated with an acute care hospital.

About 1.4 million beneficiaries use SNF services each year at a cost of about $14 billion to the Medicare program. That's almost 6 percent of total Medicare spending. CBO's recent estimates indicate that Medicare spending for SNFs will grow somewhere on the order of 9 percent annually over the next 10 years.

Medicare SNF patients differ significantly from the traditional patients in nursing facilities in that they generally require more costly services. Their share of the nursing facility population has been growing over time, as has the share of nursing home revenues financed by Medicare from about 3 percent in 1990 to about 10 percent in 2000. SNF payments per day have also grown from about $98 in 1990 to $236 per day in 2000.

Out of concern that Medicare SNF spending was rising rapidly in the early 1990s, Congress instructed CMS to implement a prospective payment system for SNFs beginning in 1998. The SNF PPS is a per diem payment system, in contrast to the inpatient PPS which is a per case system. Under the SNF PPS, patients are classified into one of 44 resource utilization groups. We call these RUG groups, based on regular assessments. These groups are then used to determine the payment amount for each beneficiary's care.

The daily payment rate for each RUG group is the sum of three components: a fixed component for routine services, such as room and board, linens, and administrative expenses; a variable amount reflecting the intensity of skilled nursing care patients are expected to require; and a variable amount for the expected intensity of therapy services such as physical, occupational, and speech therapies.

MedPAC has repeatedly raised concerns with the SNF payment system for several reasons. First, the classification system used to group patients into RUG groups fails to collect all the necessary information, including

important diagnoses and comorbidity information, to classify Medicare patients appropriately. The patient assessment instrument used to classify patients is also subject to interpretation, resulting in data that is often unreliable.

Furthermore, because the classification of rehabilitation payments is based on services provided rather than patient characteristics, the system gives SNFs strong incentives to provide therapies when they may not be beneficial. Lastly, as I pointed out in the previous slide, payment rates are calculated based on the nursing and therapy time, but not on the cost of non-therapy ancillary services, such as costly drugs, intravenous therapies, and supplies, for example.

Thus, the cost of these services are only reimbursed through the system to the extent that they correlate with additional nursing staff time. Meaning that access problems could occur for patients requiring extensive use of these types of services.

Because of these problems with the classification and payment system, Congress implemented a series of temporary payment increases, sometimes called add-ons, to the payment rates in both the BBRA and BIPA legislation. The first two add-ons both expired on October 1st of this year. Both houses of Congress have proposed extending the second of these two add-ons, the add-on to the nursing component in modified form through 2005. The third add-on is scheduled to expire whenever CMS announces a revised classification system.

Now I'll briefly summarize our workplan for the coming year in the SNF area. The bulk of our work in the next few months will center around using the payment adequacy framework to assess SNF payment adequacy for the fiscal year 2004. As always, we will look at margins, provider entry and exit, changes in volume, beneficiary access to SNF services, and SNFs' access to capital in determining whether payments appear to be adequate or not.

We will examine these measures by subgroups, including freestanding and hospital-based, urban and rural, by number of beds, by geographic region, by ownership status, and by affiliation with large nursing home chains.

In addition to our basic payment adequacy framework we will also participate in constructing a post-acute episode database which will be discussed in detail in the section immediately following this one. This database will help us look at the characteristics of patients going to SNFs and to other post-acute care settings, and to examine how these characteristics may have been changing over time.

We have also obtained a rich episode database from CMS that focuses exclusively on patients receiving care in

SNF facilities. This database links SNF claims data with the associated hospital claims data, CMS administrative data, and patient assessment data. This will allow us to analyze quality of care in SNFs since the implementation of the SNF PPS using certain preventable conditions for acute care hospital readmission. These readmission conditions have previously been identified by researchers as being important indicators of possible SNF quality of care deficiencies.

This concludes the overview. I welcome any comments or suggestions from the Commission.

MR. DURENBERGER: I have a question right off the bat because I just don't understand this, but I particularly like the analysis on the problem. What is the influence -- we're looking at Medicare payments, but because Medicaid drives so much of the organization of a skilled nursing facility, particularly the ones that are freestanding, probably much less though on the hospital side. But what is the influence on the organization to deliver care and the regulatory requirements that surround episodes of care that are influenced state by state by the Medicaid program? And is there a way to incorporate that into the analysis that you're doing here?

DR. SEAGRAVE: Up until now, the Commission has basically -- we haven't looked a lot at how Medicaid figures into the picture for SNFs. The Commission felt that we were looking at Medicare payments and we have not -- frankly, we don't have a lot of information at this point about state to state. In fact that information is difficult to gather, as you may imagine, about what's going on with Medicaid payments on a state by state basis.

MR. DURENBERGER: [Off microphone] My question was premised not on whether we should get into the Medicaid program, but when we talk about service use, resources, service needs and things like that, my experience has been is that a lot of that is dictated by the regulator process that comes with state by state Medicaid programs. It varies from time to time, and it varies even in a state like New York, from one place to the other.

I would think that it would have some substantial influence on what Medicare can or can't do, or influence in terms of its payment. I'm just trying to figure out how you could do the Medicare separate from some analysis of the Medicaid at this time.

MS. RAPHAEL: I think it is possible to get data on Medicaid expenditures and per capita, et cetera. However, I also do believe the most nursing homes have tried to maximize Medicare payments over the years. Nonetheless, I think the question for the Commission more is one that you raised in the text which is whether or not we even want to

look at the issue of compensating nursing homes with Medicaid payments below cost, and cross-subsidizing another payer.

That's something in the past we have decided that we did not want to do. That we felt Medicare should be a prudent services for its own services. But you do raise that as something that the Commission should take a look at, could possibly take a look at again.

MR. FEEZOR: Susanne, thank you. Joe stole my pen so I couldn't write down the figure that you had on what the average per day expenditure was. Is it around, $236, is that what I --

DR. SEAGRAVE: Yes, in 2000 it was $236 per day.

MR. FEEZOR: Just in suggestion, I think in some further analysis that we bring back, following up on the Senator's comment is, I think some figures around what percentage of Medicare enrollees actually in a given year participate in a SNF, something maybe around their average age if that's available, and the duration of their stays might be helpful as well.

DR. WAKEFIELD: Susanne, my guess is you're going to cut your data, to the extent you can by freestanding versus hospital-based SNFs; is that correct? So when we get data like average cost per day over time, we'll see that in those two categories, will we? Or are we focusing just on one category and not the other of SNFs? Are we focusing on both freestanding and hospital-based SNFs with this study?

DR. SEAGRAVE: No. In many cases we're breaking it down by hospital-based and freestanding. In other cases, I'm not sure, particularly with the -- actually I am pretty sure that with the payment per day we will be able to break that down by hospital-based and freestanding. Some variables we may not be able to, but to the extent we can, we certainly will.

DR. WAKEFIELD: Part of the reason I'm asking you this, and I don't have a good enough sense of this at all myself, but in talking with freestanding SNFs, at least in rural areas in my state, they assert at least that there are payment incentives at play that work against them in terms of SNF patients being held by hospitals for a longer period of time until that reimbursement has been maxed out and then discharges that follow.

I don't know how or whether you're going to be able to track any of that, but to try and get -- to use that old, worn-out phrase, ensuring a level playing field in terms of reimbursement driving inappropriate location of care, et cetera. I was just wondering if there's anything that we're going to see from you later on that would help inform our thinking on the appropriate utilization and the extent to which that playing field is level, for example,

between SNFs freestanding and those linked to hospitals.

DR. SEAGRAVE: We certainly will think about that. That's a good point. I think with some of our episode databases, either of the ones that I mentioned, we may be able to tease out some of that.

DR. REISCHAUER: Can I ask you, Mary, something? You're implying that in this area that you're talking about there's excess capacity of SNF beds and that hospital-based SNFs are keeping patients who more appropriately and cheaper would be served in a freestanding, or more convenient to their family would be served in a freestanding?

DR. WAKEFIELD: Bob, I don't know if that's the case, but I hear that anecdotally. So I was wondering if there's any data that would help us better understand what that dynamic is in terms of where those residents are being served.

MR. MULLER: But doesn't our payment policy indicate that hospitals discharge them early with that transfer --

MS. RAPHAEL: It costs more and has lower --

MR. MULLER: Yes, the payment policy says the opposite.

DR. NEWHOUSE: Because the last day should be the cheaper days.

DR. WAKEFIELD: So you're saying that would drive them out to be discharged out more quickly.

DR. NEWHOUSE: The free-standings are getting the better deal under your story.

DR. REISCHAUER: No, I think what she's saying is there aren't enough people filling the beds even.

DR. WAKEFIELD: I don't know.

DR. NEWHOUSE: That's your capacity question.

DR. REISCHAUER: That's the capacity question, yes.

DR. WAKEFIELD: And I don't know. It's only what I've heard anecdotally.

MR. HACKBARTH: Susanne, one of the questions carrying over from last year is the difference between the patients in the hospital-based SNFs versus the freestanding. To the best of my recollection, we only have very fragmentary evidence on which to evaluate the differences. Will the post-acute care database help us in any way better understand the differences?

DR. SEAGRAVE: I think either the post-acute care database, or certainly the SNF-specific episode database that we've acquired from CMS should help us be able to track the characteristics of patients going to the two types of facilities.

MR. HACKBARTH: Because that was one of the elements of our recommendations last year that I felt a

little bit uneasy about. We had some questions about whether they were in fact different, thought maybe they were, and sort of threw some money at the problem. I hope we can do better than that.

MS. RAPHAEL: I was wondering, Susanne, if you could give us an update on where CMS is in revising the classification system which we believe is so flawed.

DR. KAPLAN: CMS has decided that they are not going to refine the RUGs, and the research is still ongoing to test alternative classification systems, alternatives to the RUGs for the SNFs. But I don't expect to see anything from them other than a report by January 2005 when it's mandated that it appear before Congress.

MR. HACKBARTH: So it's safe to say that we're years away from any change in the classification system.

DR. KAPLAN: Yes, I think that's pretty clear.

DR. MILLER: Can I ask Sally one thing? And this is because I don't know. Is there a difference between the work they're doing on the refinement versus the alternative? And I wasn't clear which question you were asking. Is that a distinction, and which one was Carol asking?

DR. KAPLAN: There is a distinction, although the work is being done by the same entity. Corbin Liu is doing the work. But it is different because testing alternatives to the RUGs means that you're testing all kinds of alternatives, or any kind of alternative that you can think of. Refining the RUGs means staying within the structure of the MDS and the RUGs and seeing if you can find other things that are going to make it work better.

DR. MILLER: If I could just ask one other thing. Is the refinement as far out as 2005, or is that expected earlier?

DR. KAPLAN: My understanding is that CMS sent a letter to OMB saying that they would not be refining the RUGs.

MS. RAPHAEL: Does that mean, Sally, that the 20 percent add-on will stay in place indefinitely?

DR. KAPLAN: Until there's a new reclassification system.

MR. DURENBERGER: It's instinct to reinforce Mary's comment and what I tried to say in my comments. I understand that we can approach this at Medicare separate from some of the Medicaid issues, but in my state in Minnesota, and I'm sure, given the information that's coming in on budget deficits across the country, governors and HHS secretaries and people like that have been sitting down now for the better part of a year or two trying to figure out how to take advantage of Medicare, because it's sort of like the free pot that sits there. You can't not do this.

It's not like the old scams, whatever we called

them, in the '90s where the states were gaming the system by upping the charges. I remember it well because somehow I found myself between Governor Richards and Senator Bentsen and never the twain would meet even though they were in the same party.

But literally, this is going on as we speak and it's been going on for quite some time because -- I'll speak only for my state, they're trying to reduce the number of skilled nursing facility beds, just close up some nursing homes, and they keep looking for alternatives and so forth. But there's one pot of public money out there. Two-thirds of it is Medicaid, and 12 percent or something like that is Medicare, and somewhere, as they try to strategize sitting down with the provider groups and other people, try to strategize where are we going with this, there is a fair amount of, what's Medicare going to do? What's Medicare doing? Where can we find the least expensive to the states place for these patients going on?

I can't describe it any better than that, but it's a reality. It just points to the importance of this work, and the importance, I believe, of being quite knowledgeable about Medicaid and about what some of the states are doing and how they look at these issues.

DR. NEWHOUSE: I'd like to ask one question I've never quite been clear on. Suppose I'm a resident of a nursing home and I go into a hospital, and I have a three-day or more stay and I'm discharged to the SNF, back to the SNF where I was a resident. Now it's clearly in the state's interest to try to bill for the 100-day max. But what are the rules and policies that govern when, if at all, my state shifts back to prior pay or Medicaid, or off of Medicare, or do all of these go to the 100-day max now?

So what determines -- presumably there's something about when my acute care episode ends, but who's supposed to determine that and what are the criteria?

DR. KAPLAN: The criteria are that skilled nursing facility patients have to require or need a daily skilled nursing or rehabilitation care. The FIs basically are very stringent in enforcing that, or so they told me. Theoretically, the SNF would determine that they no longer were eligible for SNF care, knowing that they will be scrutinized by the FIs. My understanding is it isn't as easy to qualify for skilled care as it used to be.

Now when they first go from the hospital to the SNF, the RUG group basically determines whether they are qualified as a SNF in that first assessment. But the second assessment is basically that they have to determine that they do need daily skilled care or daily rehabilitation care.

DR. NEWHOUSE: This suggests an analysis to me we

might want to do, which is an analysis of variation across states or FIs, controlling for DRG, for patients that come from a nursing home, and length of Medicare stay. Because it sounds to me like there's a lot of slippage in this domain.

DR. KAPLAN: The difficulty in the data is identifying the nursing home residents. The MCBS is one way to do this. You can identify the nursing home resident that goes to the hospital, then goes to the SNF, and then goes back to the nursing home. From other sources of data that's very difficult to do because we really don't have claims for all the states.

DR. NEWHOUSE: So does this post-acute database you're going to describe next solve that problem?

DR. KAPLAN: The claims-based database that we're going to talk about next doesn't solve that problem, but MCBS data can solve the problem.

DR. NEWHOUSE: I suppose for my purpose it would be fine to pool MCBS across years to get the sample size up.

DR. KAPLAN: Exactly. And we are planning to do that although that's not what the focus of the next presentation is on.

DR. NEWHOUSE: Fine. You are planning to do what, the analysis I suggested?

DR. KAPLAN: Yes, I would like to do that. And we are planning on pooling the MCBS as well.

DR. NEWHOUSE: Good.

DR. NELSON: A fairly good percentage of people go to a SNF for a period of a week or two and then go home. The governing determinant on how long they stay there is, they and their family saying, get us the heck out of here.

DR. NEWHOUSE: That's why I started with the person who was resident in the nursing home before they went to the hospital on the assumption they'd go back to the nursing home.

MR. DeBUSK: I have a question for Sally. Sally, this classification system of 2005, is this a part of the roll-up system for the whole post-acute piece?

DR. KAPLAN: No, actually it's not. There's several different mandates. I think the one you're referring to is the mandate that CMS identify a uniform, functional assessment instrument, and health status instrument to use across all settings in Medicare, meaning acute care hospitals, rehab, outpatient, everything. That is a separate mandate from the mandate to test alternative classification systems for the skilled nursing facilities.

MR. DeBUSK: That's due about the same time, isn't it?

DR. KAPLAN: It is. They're both due in January 2005.

MR. DeBUSK: So how's that going to work?

MR. HACKBARTH: Given that we're going to have to live with this classification system for years into the future, and presumably therefore we'll continue to have the add-on that was designed to offset, ameliorate deficiencies, is there anything that we can do in the shorter run to analyze whether in fact the add-on is helping, is properly targeted, too much, too little?

DR. KAPLAN: I think that the SNF-specific database that Susanne was talking about will allow us to look at patients by groups and how well payments match costs by RUGs group, and maybe we can target that money more effectively than it's being targeted now. There's a lot of thought that the targeting is not really great, and that might help.

I'm not sure we can do that by March but I think we can certainly try. But since this problem isn't going away, if we can't do it March, it's still an important thing to try and do by June or so.

MR. HACKBARTH: Any other questions or comments?

Okay, thank you, Susanne.